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ABSTRACT

This paper explores the ways of speaking emerging in a Japanese hospital in response to adoption of a foreign concept, "preceptorship," a nursing educational program for training novices in real working environments. The paper notes that although the program was first developed in English-speaking countries, Japanese nurses have recently begun to import it into their terms of nursing education, using the foreign word "preceptorship," even though it might be differently interpreted due to cultural differences. The paper details ethnographic observation of the nurses at Osaka University Hospital--their patterns of communication in light of their organizational knowledge and behaviors which enable them to make their knowledge practical. It describes the nurses' explicit ongoing processes of constructing the distinctive codes of communicative acts as preceptors or preceptees. Specifically, it analyzes two tensions in the import of the concept "preceptorship": the primary tension arising in the process of adapting and enacting an unfamiliar concept, and a secondary tension arising following the anchoring processes, where nurses rethink their own senses of the value of their roles as nurses. Research data were collected by participant observation, ethnographic interviews, and analysis of written narratives. The paper concludes that the nurses did not feel much difficulty in anchoring a foreign concept to their nursing practices and education. It finds that they interpreted preceptorship in their own ways, comparing it with similar concepts; however, its togetherness, one of primary concepts of preceptorship, invoked controversial utterances. (Contains 32 references.) (NKA)

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Running head: PRECEPTORSHIP

When a Preceptor Meets "Preceptorship": Dialectics in Japanese Nursing Preceptoring Relationships.

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Introduction

"Preceptorship" is a nursing educational program for training novice nurses in real working environments. It is a kind of mentorship based on a one-on-one dyadic relationship between a preceptor and a preceptee. "Preceptorship" is an English term because this program has been developed mainly in English-speaking countries, the United States and the United Kingdom. However, now it becomes global; recently Japanese nurses began to import it into their terms of nursing education. This essay is an ethnographic exploration of the ways of speaking emerging in a Japanese hospital in response to adoption of this foreign concept, "preceptorship."

When you import foreign products and concepts to your own country, you usually call them by their native names -- the names which come with them. However, the native names do not mean that you understand them in the native ways. In other words, even though such products or concepts are called by the original words in the original language, they might be differently interpreted due to the cultural differences. Shotter (1993) argues that we "should see the *use* of a word as a *means* of (but only as *one* means among many others) in the social making of a meaning" (p. 28, italics in original) rather than assuming that it has already had a meaning. In reality, this means that discourse becomes the central issue to understanding the localized meanings. By focusing on the practical usage of words, we can access how people construct their knowledge of a foreign concept because talk and use of texts are parts of social practices (Potter, 1996).

The importing of a foreign word through foreign concepts evokes an interesting discussion on micro-macro linkage between individuals' experiences and social knowledge. As Berger and Luckmann (1966/1967) state, our knowledge of everyday life is structured in terms of relevances; and the basic relevance structures referring to everyday life are presented "ready-made by the social stock of knowledge

itself" (p. 45). However, we do not have a social stock of knowledge about a new concept which we have never experienced. As the theory of social representations (Moscovici, 1984) shows, first we make an unfamiliar object fit given categorical systems; then, when this is not sufficiently successful, we make given categorical systems fit to the object (Flick, 1995). Billig (1991) argues that we should not confine this "anchoring" (Moscovici, 1984) to a one-sided cognitive process, and suggests that we should pay more attention to the role of argumentation, namely, a critical two-sided activity where one thing is located relative to competitive and contrary concepts. Billig (1991) states that "if we can categorize or anchor information, we can also do the opposite: we can particularize information and treat it as a special case, thereby negating, or criticizing, a strategy of categorization" (p. 73).

Therefore, the importing of a foreign concept should not be regarded as the simple cognitive modification of the traditional category system. Rather, it provokes a more complex dialectical activity between the original concept and the modified versions which refer to newly constructed knowledge in the new culture. Thus, a new concept is not reduced to a part of a pre-existing category; instead, it becomes the basis for a revisionist genre, that is "a way of speaking associated with a form of the social life with a 'history' to it" (Shotter, 1993; p. 180). Hymes (1972) states that a genre implies "the possibility of identifying formal characteristics traditionally recognized" (p. 65). Therefore, the utterances within a genre refer to both tradition and changes in the social life. Since a genre is sociohistorical (Todolov, 1981/ 1984), a new genre can transform people's social life. Importing a new word can act as the force in creating a new tradition of a speech community, and a dialectical tension arises between both new and old traditions in its members' utterances.

The Japanese nurses in Osaka University (Medical) Hospital (*Osaka-daigaku Igaku-bu-fuzoku Byoin:* as known as *Handai-byoin*) began to experience this dialectical tension when the Office of Nursing Administration decided officially to adopt "preceptorship" as their new program of training nurses.

"Preceptorship" refers to a mentoring program for newly graduated nurses (Morrow, 1984). Basically, it is a one-on-one training program like tutoring rather than classroom one-to-many teaching; at the workplace, however, both preceptor and preceptee work together as full members of the hospital ward. Preceptorship enables a new staff member to become accustomed to his or her task and also to his or her working environment through praxis. In the United States and the United Kingdom, since 1970s many hospitals have adopted "preceptorship" for the education of new nurses. Following the success in these countries (Yoshii, 1992), some hospitals in Japan have recently begun to adopt "preceptorship" programs. Thus, the preceptorship program is an excellent site to study the practical leaning that takes place as new concepts are leaned, but it also is a good site for studying discourse between the two involved parties.

Problems in the Adoption of "Preceptorship"

As noted above, the implication of the notion of the "preceptorship" creates several problems. Most Japanese practicing nurses, including nursing administrators, still do not have more than vague images of "preceptorship," partly because they do not have enough information. Very few articles on "preceptorship" have been published in Japanese nursing journals. Moreover, most nursing journals only discuss theoretical perspectives; therefore, nurses find it particularly hard to bridge the gap between theory and practice. In short, the established nurses do not really know what they should be doing to fulfill their role as preceptors. Although research papers published in the United States and the United Kingdom are available in most university libraries, two major barriers exist for the Japanese nurses trying to access this information: One is language and the other is the differences in Japanese educational and managerial systems. The third is that nurses are not encouraged to read these sources. Since "preceptorship" is praxis, and since praxis differs in different countries, the examples in the foreign country are no more than

hints for Japanese nurses to improve their training system. Therefore, the introduction of "preceptorship" makes Japanese nurses interpret this new program through their own cultural understandings and create their own meanings of it in their practice.

The Osakan nurses' new project gave me an opportunity to observe their patterns of communication in light of their organizational knowledge and behaviors which enable them to make their knowledge practical. In other words, what the nurses of *Handai-byoin* needed was not straightforward explanation of the concept using the abstract rules of language but rather what Hymes (1962) terms communicative competence, that is, the tacit social, psychological, cultural, and linguistic knowledge governing appropriate use of language (Schiffrin, 1994).

In the case of *Handai-byoin*, however, nurses did not talk of *tacit* knowledge about preceptorship because they had not had a chance to make it *tacit*; the term had not existed in their organizational culture prior to the nursing administrators' decision of official adoption. In terms of "preceptorship", therefore, as an ethnographer, I was able to participate in the nurses' *explicit* on-going processes of constructing the distinctive codes of communicative acts as preceptors or preceptees. These speech codes implicate distinctive thematizations of the ends and means of social actions (Philipsen, 1992).

On the other hand, talking about "preceptorship" not only produces new speech codes, but also exacerbates relevant *tacit* knowledge, such as, 'What is nursing?' 'What is education?' 'What is leadership?' and so on. Flick (1995) argues that anchoring in the theory of social representations can be regarded as the retrospective narratives of how narrators have encountered the unfamiliar. As Bruner (1990) states, narratives refer to both canonicality and deviancy in folk psychology as common sense. Therefore, talking about the unfamiliar evokes talking about the familiar. Thus, constructing new speech codes about "preceptorship" evokes the same process as evaluating existing speech codes regarding nursing and relevant issues.

This ethnographic research will contribute to communication studies in terms of my conclusions regarding the analysis of dialectical tensions evoked by importing a foreign concept. More specifically, I analyze two tensions in the import of the concept "preceptorship." First, the primary tension arises in the process of adapting and enacting an unfamiliar concept, and secondly, a secondary tension arises following the anchoring processes, where nurses rethink their own senses of the value of their roles as nurses. As I discuss in the next section, since "preceptorship" assigns multiple roles to preceptors, it functions to make them reconstruct their identities as nurses through the negotiation with this new concept. In other words, "preceptorship" is a catalyst which enables both nurses and researchers to see the social construction of the identity of "nurse," and also allows both "old" and "new" nurses to see the identity of "nurse" in ways that will ultimately align themselves.

The latter tension, that is, the tension among multiple roles, brings us a rich potential in situated theories of communication which can potentially contribute to the nurses' meaning-making of "preceptorship." From the social constructionist view (Burr, 1995, Potter & Wetherell, 1987), our knowledge is spoken in the form of "interpretive repertoires," a stock of culturally available linguistic devices used to perform different sorts of accounting for it. Potter and Wetherell (1987) furthermore emphasize that "what is predicted is exactly variability rather than consensus" (p. 156). Carbaugh and Hastings (1995) state that the idea of community "is not merely a reaffirmation of simple consensus but erects a complex notion of community that spans consensus and conflict (p. 182)." I would argue that the central issue of ethnography is not agreement among participants, but coherence of the discursive system to the participants' social positions and relationships. I contend that conflicts among interpretive repertoires in ethnography can help the participants reflect on the world which they construct since communities differently position members and are sometimes subsequently laden with disapproval and conflict (Carbaugh, 1994; Carbaugh & Hastings, 1995).

Situatedness was very important in the ethnographic research in this project because it had an aspect of joint project with the Office of Nursing Administration as I will explain in more detail. My research questions derived from preceptors' struggle of conceptualizing and practicing "preceptorship": How was the concept of "preceptorship" localized in *Handai-byoin*? What did it mean to preceptors?

The Concept of Preceptorship in the United States and the United Kingdom

Preceptorship has not been widely discussed in either the United States or in the United Kingdom. Following the two books (Morrow, 1984; Stuart-Siddall & Haberlin, 1983) that were issued in the United States in mid-1980s, no nursing book title contains "preceptorship." However, many research papers and literature reviews refer to Morrow's (1984) theory of preceptorship.

According to Morrow (1984), preceptors are responsible for four functions: clinical practice, teaching, consultation, and research. Preceptorship was originally designed to educate and support novices, especially, to help them overcome their "reality shock" (Kramer, 1974), which is the shock between their expectations and actual reality. However, I carry the function of this term further to argue that preceptorship not only benefits preceptees but also contributes to the development of preceptors.

Preceptorship is an educational system which is similar to apprenticeship, which is based on the one-on-one relationship between preceptors and preceptees. However, there is no overarching law which defines the proper length of preceptoring period nor the best method of preceptoring. Although many articles refer to the selection of preceptors and emphasize the importance of their clinical expertise, interpersonal communication skills and leadership (de Blois, 1991; Kramer, 1993; Morrow, 1984), most criteria are arbitrary. Bain (1996) suggests that baccalaureate nurses should be suitable for the roles of preceptors; however, she is afraid that selection based on degree may limit the availability of

preceptorship.

Although the establishment of the one-on-one relationship during preceptorship is its characteristic, what is most important during preceptorship is supervision and evaluation of preceptors by head nurses and other managerial staff nurses (Morrow, 1984). Furthermore, nursing administrators are responsible for the education of preceptors; and most authors recommend at least a one or two day preparatory workshop for prospective preceptors (Bain, 1996; Morrow, 1984, Piemme et al., 1986). In other words, the preceptor/preceptee relationship has two aspects: the dyadic relationship, and, the relationship as integral to the systematic organization.

Preceptorship is not an ideal educational system; as with any system, it has its disadvantages and limitations. Brennan and Williams (1993) state not enough empirical data exist to prove the effectiveness of preceptorship; furthermore, they point out the danger of "unsuitable pairing" (p. 36). Although Morrow (1983) spends one chapter on coping with conflicts in preceptorship, no empirical research has yet delineated ways actual conflicts were resolved.

Finally, confusion exists in the very definition of the term preceptorship. Most authors emphasize the importance of teaching and mentoring in the function of preceptorship, and therefore do not differentiate preceptorship from other synonyms such as mentor or teacher. However, other authors attach greater importance to the role of preceptor as practitioner (Brennan & Williams, 1993). Furthermore, Armitage and Burnard (1991) argue that the role of preceptor should be quite different from that of mentor. In their words, "[T]he mentor role seems to be more about 'looking after' the learner nurse, whilst the preceptor role seems to be more concerned with enhancing clinical competence through direct role-modelling" (p. 228). Bain (1996) underscores my argument that most literature has not yet clarified the definition of preceptorship.

Along these lines, my informants in *Handai-byoin* were also frustrated with a similar ambiguity in,

the term. For a long time, most hospitals adopted on-the-job training programs of novice education by one-on-one pairing of experienced nurses with novices. Such training programs were named "Pair system," "Elder system" and so on. Therefore, preceptorship is regarded as a synonym of these programs. However, I argue that preceptorship is dramatically different in terms of preceptors' responsibility for their preceptees' education; previous programs have more focused on senior nurses' care-taking instead of education. Moreover, while previous one-on-one training systems were invented in accordance with each ward's convenience, preceptorship should be supervised by the Nursing Administrators, since it is an official education program. Thus the Office of Nursing Administration must plan preceptors' workshop for the preparation and publish manuals of preceptorship.

However, since preceptorship depends on the policy of each ward's head nurse, some preceptors have had difficulties in finding their organizational identity as preceptor, wondering "WHO am I?" as well as "WHAT's new in preceptorship?"

General Background of Japanese Nurses

Education

In Japan, as well as in other countries, nursing licenses for a Registered Nurse are issued to those who have taken sufficient education for nurses and have passed the official examination offered by the Ministry of Welfare. Five courses fulfill the required education including non-degree courses and baccalaureate course; however, the number of baccalaureate nurses is still low. Many nursing administrators do not necessarily graduate with a Bachelor's or Master's degree. A more common route is for national and prefectural associations or hospitals to offer workshops for management and education

skills. In other words, most Japanese nurses (most of whom are female) learn staff development in their workplace, instead of at universities or colleges.

Management

The typical nursing organization of hospital ward is very simple; it usually has two or three managing staff: one Head Nurse (*Fucho*), and one or two Vice-Head Nurse(s) (*Fuku-fucho*, or *Shunin*). In *Handai-byoin*, each ward has two Vice-Head Nurses, titled *Fuku-fucho*; this position was newly established in 1993. One of the two Vice-Head Nurses is in charge of clinical practice (*Gyomu-Tanto*), and the other is in charge of nursing education and staff development (*Kyoiku-Tanto*). However, the status of Vice-Head Nurses is ambiguous because these persons are also responsible for the same tasks as other staff nurses, including working night shifts. Preceptors are appointed from the staff nurses at the discretion of these managing staff in each ward, rather than by the Nursing Administrators who manage the whole hospital. In Japan, therefore, preceptor nurses are not experts in education, since they are appointed temporarily and are equal to other staff nurses in terms of tasks and wages.

Newly graduated Nurses and Their High-Rate Turnover

In Japan, the academic year begins on April 1st and ends on March 31st. New nursing graduates are generally employed on April 1st, when the novices are counted as staff nurses. Yet because there are few changes in the number of staff nurses, every hospital suffers from a decline in performance because of the unexperiencedness of novices in the first quarter of academic year -- from April through June.

In Japan, as well as in the United States, "reality shock" (Kramer, 1974) is the primary issue for

newly graduated nurses. Although they are novices, all people in the hospitals (that is, patients, doctors, paramedicals, visitors, and nurses) expect them to work as efficiently as other staff nurses. Most nursing administrators in Japan regard "reality shock" as the primary reason for the high turnover among novice nurses. Although newly graduated nurses have already fulfilled their compulsory internship in their third year of nursing college, this fact does not ease the "reality shock" because interns do not have their own workload.

In terms of the job market, in general, the position of staff nurse is not as competitive as other professions because of its high turnover rate, and therefore, presumably the high numbers of people available to refill vacant posts. However, although every hospital suffers from the shortage of nurses, their positions within university hospitals are relatively competitive. For instance, *Handai-byoin*, the site for this research, is one of most prestigious university hospitals in Japan. In general, the majority of the nurses in a university hospital are alumni of the university or its junior college. Therefore, some of novices have been to the hospital in their internship.

Method

Field

Osaka University (Medical) Hospital (OUH: *Handai-byoin*), Suita, Osaka, Japan. Suita is a city in the northern suburban area of Osaka, the second largest city in Japan. The city has been developed dramatically since the Expo (World Exhibition) of 1970. The hospital, which will be referred to here as "*Handai-byoin*" ("*Byoin*" means hospital in Japanese), belongs to Osaka University (*Osaka-daigaku*, or *Handai*), one of Japan's seven most prestigious national universities (*Kyu-nana-teidai*). The hospital

holds 24 wards for inpatients in addition to the wards for outpatients, and operations, as well as the central radioactive unit, the rehabilitation ward, and the equipment administration office.

The new 14-story (plus 2 stories underground) hospital building was built in 1993, with two wings: the East wing for internal medicine; and the West for surgery. The current hospital building was newly built in 1993.

My primary field was the 11th floor -- that is, the 2nd ward of internal medicine (the section for diabetes, heart disease, blood disease, etc.) in the East wing, and the 2nd ward of surgery (the surgery for digestive systems, cancer, etc.) in the West wing. Since nurses call wards by both Wing and Floor, these two wards are called "*Higashi*-11 (East-11th)" and "*Nishi*-11 (West-11th)," respectively.

I chose these two wards for two major reasons. First, the head nurses of both wards had positively adopted preceptorship in the education of novices and, furthermore, established systematic theories on preceptorship. (However, it does not mean West-11th had successfully adopted preceptorship, because Shimura-*fucho-san*[1] ["*Fucho*" means "Head Nurse," and "*San*" is a suffix equivalent to "Mr. Ms. Mrs. or Miss" in English], the Head Nurse of West-11 was newly transferred to there in November 1994; therefore, her experience was in her previous ward.) Second, both wards needed two or more preceptors in the academic year of 1995; therefore, I could observe two or more preceptorships in each ward. There were two and four preceptorships in East-11th and West-11th, respectively.

Method

In this research, I used three strategies for collecting data: participant observation, ethnographic

[1]All names in this paper are pseudonyms. All nurses in this paper are female.

interviews, and analysis of written narratives.

Participant observation

The Hospital personnel allowed me to observe the wards; however, I did not participate in medical or paramedical practices (because I did not have a nursing license), and yet, the *fucho-san*s of both wards gave me a permission to stay in the nurse stations. Fujiwara-*fucho-san*, the head nurse of East-11th even permitted me to read patients' case records since she believed case records represent the development of novices. Both *fucho-san*s asked me to wear a white gown, which enabled me pass as a "medical staff" in the ward. Actually, some doctors mistook me for an intern. Fujiwara-*fucho-san* said that if there was a person in plain clothes in the nurse station, the patients would be dubious.

The *fucho-san*s clearly defined my accessibility in the wards: I was permitted to stay in the nurse station, walk on the corridors, and go to the bathrooms. However, I was prohibited from the sickroom and from talking to patients, and I was not allowed to interview doctors because they were outside the nursing administration.

In the field, I always carried an A-5 size (the half of A-4: A-4 is roughly the same as US letter.) notebook, with a three-color ballpoint pen; I needed three colors because I mainly visited three different workplaces, the two wards, East-11th (where I took notes in red ink) and West-11th ward (where I took notes in black ink), and also the Office of Nursing Administration (where I used blue ink). Whenever I wanted to take notes, I opened the notebook. Nurses were aware of my note-taking; however, they did not consider it strange, because they were also always taking notes -- writing their patients' records -- moreover, also with three-color ballpoint pens.

My role was as an observer-as-participant. As Lindlof (1994) discusses, when observing is the

chief instrument, "the observer-as-participant tries to record and understand the behaviors that fit the categories of interest" (p. 147). What I primarily noted mainly was the communication and behaviors which had something to do with preceptees. When preceptees were on my shift, I paid more attention to those who were communicating to preceptees. Even when preceptors worked elsewhere, my focus was on preceptees, since I could observe how other staff nurses played roles of their temporary preceptors.

Both *Fucho-sans* permitted me to observe both "*Jun-ya* or *Jun-yakin* (Early night shift: 4:30 PM - 12:30 AM)" and "*Shin-ya* or *Shin-yakin* (Midnight shift: 12:30 AM - 8:30 AM)" as well as "*Nikkin* (Day shift: 8:30 AM - 4:30 PM)." How long I stayed in the field depended on "*Kimmu-hyo* (the table of monthly schedule of shift in a ward)" and my own schedule. I stayed there for 12 hours at most; I visited at 10 PM to observe nurses' night shifts. On the other hand, when I spent more than an hour talking with Nursing Administrators, sometimes I could stay in the wards for only half an hour in each ward.

Fujiwara-*fucho-san* utilized me as a resource for the preceptorship in East-11th, and invited me to the meeting of *Fucho*, two *Fuku-fuchos*, and two preceptors in May 1995, and asked me to report what I had seen so far.

Ethnographic interviews

Both *fucho-sans* permitted me to talk to staff nurses while they were working so long as I did not interrupt their work. Actually, it was very difficult to get opportunities to ask them questions because they always looked occupied; they often disappeared and reappeared frequently and abruptly like sprites. Therefore, I usually spoke to staff nurses when they began the conversation with me.

When I wanted to know my informants' views on preceptorship in more detail, I asked them to allow me to establish interview sessions. I interviewed those who were directly involved in the

preceptorship -- preceptees, preceptors, head nurses, and vice head nurses. When I solicited an interview, I usually let them choose a suitable place. Interestingly, whenever I interviewed in West-11th, it was primarily in the "Testing Room (*Kensa-shitsu*)," which was used often as a conference room, although each ward has a "proper" conference room. On the other hand, the places for interviews in East-11th were various: their "proper" conference room, other rooms used as alternative conference rooms, the "Day Room" or the public area for patients and visitors, and even the "*Kyukei-shitsu* "(staff's resting lounge).

My interviews were unstructured. I asked the same question: "What do you think of the preceptorship?" To preceptors, I also asked about their first year as nurses. To managerial nurses, I asked about the past educational systems in their wards and of their plans for their preceptorships.

When I made appointments with the nurses, I told them it would take about half an hour for an interview; however, it sometimes took an hour because I let nurses talk as long as they wanted. Some nurses were very talkative, and some were not. It was hardly possible to interview a nurse without making an appointment; however, no one refused an interview.

I did not record the interviews because I was afraid that tape-recording might make nurses cautious rather than candid. It was not a groundless anxiety; in the early period, I had a problem with a preceptor. Because I had heard she did not agree with my research, I asked my advisor (at Kyoto University) for some advice. When he talked about it to Nursing Administrators, they called her to the office and asked her for a reason -- or justification; this trouble horrified her. Later she confessed to me, "For us, *Kango-kanri-shitsu* (the Office of Nursing Administration) is the place to fear. Once they take us for troublemakers, we won't have any chance in the hospital." Some nurses were cautious of me because they regarded me as an agent from *Kango-kanri-shitsu*.

It is reasonable that some nurses associate me with *Kango-kanri-shitsu*; I was allowed to visit there by their reference. Nursing Administrators had offered this favor because I could help them grasp how

actual preceptorships were going on in the wards. In other words, they could see that my research had an aspect of a joint project with the Office. In order to comply with them, I submitted reports based on my fieldnotes to the Office twice, one at the beginning of May 1995, and the other at the beginning of July 1995. In addition to them, prior to this project, I had participated in nurses' workshops twice, as an assistant of the instructor, who was my advisor at that time.

During this project, I also joined in the three-day workshop for *Chuken* (mid-range: the nurses who have three to five years of experiences) in June 1995. This workshop was specially aimed at conceptualizing the notion of preceptorship, and we planned to replay preceptees' voices to the participants because many of them were in charge of preceptors. I used this opportunity to collect more preceptees' voices, and *Kango-kanri-shitsu* kindly introduced me to five newly graduated nurses in addition to the six preceptees on the 11th floor. I interviewed these five preceptees in the library of *Kango-kanri-shitsu*. Though Nursing Administrators did not attend the interviews, the interviewees seemed to think that they had been called by people in *Kango-kanri-shitsu*.

Since the mutual cooperation with *Kango-kanri-shitsu* was indispensable for my project, it is natural that some of my informants were cautious of its "shadow." However, I did not feel any disadvantage due to this "shadow" in my interviews. Indeed, I might have lost some "frank" voices; nonetheless, they talked more about what they thought than when they might talk to Nursing Administrators. Actually, managerial nurses were very surprised at nurses' voices which I collected.

Though I did not tape record any interviews during the main period of this project (February - August 1995), I recorded interviews or conversations with my informants when I revisited *Handai-byoin* in May and June 1996. All informants were willing to give me permission to record their talk. However, I asked only a few of my informants with whom I believed I had established rapport in the main period of the research. Therefore, I do not believe I should have recorded any interviews when I was doing

participant observation, for I wanted to collect voices from those who did not seem to trust me.

Written narratives

One of the advantages I enjoyed in the cooperation with *Kango-kanri-shitsu* is the access to nurses' written narratives. In three-day workshops, *Kango-kanri-shitsu* assigns two reports to the participants: one is a pre-workshop report, and the other is a post-workshop report (During the one-day workshops, only a post-workshop report is assigned). I had opportunities for reading the reports while helping the Nursing Administrators summarize them.

In the three-day workshop for *Chuken* in June 1995, my advisor, as the instructor, asked the participants to write personal essays for a manual on preceptorship and on *Chuken* nurses' leadership. These essays revealed vivid experiences and actual practices in *Handai-byoin*. I proofread and edited the manuscripts in July 1995 and made an effort to conceal identities of the authors; *Kango-kanri-shitsu* published the booklet and distributed the copies to each ward in the hospital.

This booklet contains very rich data in terms of variety and multiplicity of voices because some *Chuken* nurses referred to preceptees' voices which I presented in the workshop. After collecting eleven preceptees' voices prior to the workshop, I divided them into anonymous excerpts. During the workshop, my advisor asked the nurses tc write their own "manuals" of preceptorship; some participants furthermore wrote responses to my presentation -- the preceptees' voices in my presentation. My advisor was so impressed with the "manuals" that he asked participants to rewrite their manuscripts for publication. Consequently, the essays in this booklet consist not only of multiple voices of *Chuken* nurses but also of preceptees' voices.

My viewpoint

As an ethnographic observer, I had a unique position within the ward. Because I was an outsider, people in the organization were equal; I could talk with "*Kango-bucho* (the CEO of nursing department)" frankly, as well as interview preceptees on their preceptorships. Fukakusa-*san*, one of the Nursing Administrators, told me that, in the *Fuku-fuchos*' meeting in July, *Fuku-fuchos* were surprised at the "frank" voices from preceptees which I presented at the *Chuken* workshop in June, and that some of *Fuku-fuchos* wanted to know how to elicit preceptees' voices. Fukakusa-*san* laughed and said to me, "Then I said to them (*Fuku-fuchos*), 'They (preceptees)'ll never tell YOU what they think even if you learn some interviewing skills.'" I laughed and said, "I did nothing, just asked them." And yet, Fukakusa-*san* was right; the preceptees told me what they honestly thought about their preceptorships because they knew I was NOT a member of *Handai-byoin*.

However, I do not believe in the wisdom of accepting an omniscient point of view to preceptorship in *Handai-byoin*, since it may cloud my vision in viewing correct answers to my research questions regarding how nurses localized the concept of preceptorship, and what preceptorship meant to their social lives. As Emerson, Fretz and Shaw (1995) point out, an omniscient view may "reduce and blend multiple perspectives into accounts delivered in a single, all-knowing voice" (p. 59). I was actually criticized for producing a single voice: Shimura-*fucho-san* of West-11th commented on my first report on the preceptorship in April: She said to me, "Masuda-*san*, I enjoyed your report. Some of your comments are correct, but some are different from my understandings. But it's OK because it's what YOU saw. But, Masuda-*san*, please don't forget to see them (the nurses) from different views."

Given Shimura-*fucho-san*'s "fair" critique, I now examine multiple points of views. I applied this to my ethnographic style. In addition to my fieldnotes and interview notes, I began to utilize multiple

voices from the booklet of chuken nurses' essays.

Analytical Method: Domain Analysis

I adopted Domain Analysis for the analysis of the *Chuken* nurses' written narratives in the booklet. Since this ethnographic research aims to investigate how the nurses of *Handai-Byoin* made sense of the new term "preceptorship," I, as an ethnographer, need to take their ways of explaining it. I contend that Domain Analysis (Spradley, 1979) is the most suitable analytical method for finding out the nurses' native meanings of "preceptorship," which are not given by the theory of "preceptorship" but constructed through their own experiences. Here, a domain refers to "a set of symbols that share meaning in some way" (Coffey & Atkinson, 1996, p. 91). Domain analysis shows us the semantic relationships between the core term and other folk terms.

According to Spradley (1979, pp. 110-111), there are nine types of universal semantic relationships in all human cultures. Among them, my study is concerned with six semantic relationships; Strict inclusion: X is a kind of Y, Cause-effect: X is a result of Y, X is a cause of Y, Rationale: X is a reason for doing Y, Function: X is used for Y: Means-end: X is a way to do Y, and Attribution: X is an attribute (characteristic) of Y; because the aim of the workshop is conceptualizing preceptorship, Spacial, Location for action, and Sequence are not relevant categories. As an organizational technique, I chose words or sentences which refer to preceptorship, novice education, preceptor, and preceptee in the booklet, and classified them into six semantic relationships.

Findings

Morrow's (1984) four function model (preceptor as practitioner, teacher, consultant, and researcher) did not help preceptors conceptualize preceptorship; rather, it just perplexed them. These concepts did not relieve them from anxiety about their forthcoming new tasks. At the prospective preceptors' workshop in March 1995, Bando-*san*, the CEO of Nursing Department asked them whether they tried looking up the word "preceptor" in an English-Japanese dictionary. None had done so. It was a subtle, but very interesting episode for me; when I had heard about preceptorship, My first act was to consult a dictionary for its original definition.

Autonomy as Professional Pride

What nurses wanted was a method of establishing this peculiar dyadic relationship by negotiating their professional pride -- autonomy. Indeed, most preceptors wanted to get along well with their preceptees and be good friends; on the other hand, they felt a confinement due to the mandatory pairing by the head nurses. Even greater than this relational aspect of autonomy, their primary concern was professional. They feared that preceptorship might prevent both preceptors and preceptees from making professional progress, by shackling their professional autonomy. Thus, my primary finding in this research is that nurses' professional pride is grounded on their autonomy: Nurses must choose, decide, and learn everything by themselves; however, the connectedness of preceptorship violates this primary principle.

From the domain analysis of the essays, I analyzed six themes of attributes of preceptorship:

(A) Burden: "I regret I accepted this appointment without thinking carefully about it." "I don't want to carry the burden only by myself."

(B) Caution "We're cautious of each other." "I'm a coward."

(C) Preceptor's immaturity: "I fear torture by new nurses' questions." "I'm afraid my advice is biased."

(D) Boredom: "We've been getting bored with each other because we've worked together everyday."

(E) Intimacy: "I miss my preceptee when I don't see her face." "My preceptee does very well, admirably."

(F) Togetherness: "A goldfish and its excrement (Japanese idiom which means 'Trailing someone around like his or her shadow.')."

The concept of "Burden" originates in the preceptors' heavy workload and responsibility. In some sense, they have to do two persons' work because of the preceptees' lack of experiences. This burden restrains the preceptors' autonomy. When I interviewed prospective preceptors in 1995, before their preceptees began to work at their ward, some of them told me that such a burden would end in just spoiling preceptees, and would be nothing more than depriving preceptees of their important opportunity to learn autonomously.

Yokota-*san* (4 years of experiences, 25 years old) of West-11th doubted preceptorship should create the intimate relationships the theories recommend. "I feel something resistant to preceptorship," she said. "One concern -- one thing I don't understand is why preceptors should take care of preceptees' private lives -- even health conditions. I wonder why they demand preceptors so much. If they come to the hospital to work, they should take care of themselves for themselves -- such as -- their own business. It's a principal attitude as nurses, working in three shifts. Maybe I lost what I felt in my first year... But, I would say, OK. I'll tell you everything about work, because I was taught in the same way. But, I don't know about controlling health conditions. Actually, I still feel it difficult to control my own condition; why should I consider other's?"

Motokawa-*san* (5 years of experiences, 26 years old) of West-11th was also afraid that preceptorship might violate the nurses' autonomy and independence. She agreed in general with the objectives of preceptorship, as when she said, "Preceptorship is really great. I wish we had been trained by this kind of program." However, she referred to the theme of "Caution": "But the other day, when I talked about it on the phone with an ex-*Kouhai* ('*Kouhai*' refers to the person who has less experience in an organization.) who'd left the hospital, she said to me, 'But I'm afraid it (preceptorship) could spoil novices, on the contrary. If she (preceptee) is wide-awake, you'll be used by her as much as she want.' I haven't imagined such a problem."

Other preceptors worried that they might fail to disclose their preceptees' ability, and that preceptorship might prevent both from professional progress. Kiuchi-*san* (5 years of experience, 26 years old) of West-11th had no idea of preceptorship when she was notified of her appointment. Then, she attempted to figure it out by comparing it to a similar program in internship of medical education. "When I heard about preceptorship, I thought it might be similar to '*Oben*' ('old' in German; in Japanese medicine, people use German for their basic terms unlike nurses who use English for most of their basic terms.). In May, new interns come to the hospital for one-year internship. When new interns come, old interns still stay by the end of May to mentor the new interns by one-on-one. So, whether a new intern is lucky or unlucky depends on his or her *Oben*. I don't think this system is well-balanced."

Kiuchi-*san* was concerned about the same problem of an "unlucky" new intern due to "*Oben*s'" individual differences and she thought that "Preceptor's immaturity" would occur in preceptorship. She said to me, "I have no idea of what's coming. It depends on my prospective preceptee's personality, stamina, and habits. I don't know how I should do. All I can do is do preceptorship with her, together. My skills of nursing practice are not guaranteed; I might be wrong. It is not the years of my experience but I, myself, who teach her. So, it's probable I'd make a mistake; if so, both of us will go under together,

I'm afraid." She wondered whether it were possible to teach her preceptee in a way which would meet her preceptee's personality. "To be honest, I think preceptees should be taught by various people, though preceptees might be perplexed. I think it better that everyone teaches a novice; even when her preceptor makes a mistake, it'd be relatively easier to keep her on the right track. I wonder if one-to-one advising is really suitable. I feel a sort of fear. I think other staff nurses should organize a committee which supervises preceptorship." Her primary concern was maintaining herself; "Anyway, we (Kiuchi-*san* and her preceptee) will have two choices: We'll enable each other to progress, or we'll deteriorate each other. Preceptorship is so risky that it might destroy myself. If I dedicate myself to it too much, I'll be surely broken. To think like this... it's a heavy burden."

The less experienced the preceptors were, the greater they suffer from this concern. During my interview, Kusakabe-*san* (3 years of experience, 24 years old) of East-11th talked about her anxiety -- not only particular to her but common to her *Douki* ("*Douki*" means the nurses who had the same years of experience in *Handai-byoin*). In her view, preceptorship is a burden to a nurse with only three years experience. "I met several *Douki*s in my junior college (She had graduated from the Junior College of Nursing at Osaka University) at the (prospective preceptors') workshop. Everyone feels anxiety as I do. What on earth can we -- such (immature) nurses like us -- teach novices? We can't take care of anyone but ourselves," she said. Her second concern was due to the gap between her insufficient nursing skills and her responsibility; she said, "If my preceptee were a preceptee of that *Sempai* ("*Sempai*" means a more experienced person in a organization; it is an antonym of "*Kouhai*."), she would learn much more. She might be unlucky simply because I'm her preceptor. I'm afraid I'll fail to disclose her ability."

My finding showed, however, that mandatory pairing of preceptorship does not necessarily restrain the nurses' autonomy. No one actually replaces the preceptors' position, thus preceptors have the opportunity to be independent of other staff nurses in terms of novice education. In other words,

preceptorship is also a good opportunity for *Chuken* nurses to set them free from the protection of more experienced nurses ("*Sempai*") and to be leaders in the wards. In fact, Kusakabe-*san* was aware of the change of her status in the ward: As a fourth year nurse, she was no longer a trainee but a trainer.

Kusakabe-*san* pointed out a different kind of autonomy from Yokota-*san*. Yokota-*san*'s autonomy is based on working as a nurse -- a professional. Actually it is very difficult for nurses to be dependent of their colleagues because everyone works in a different schedule. Moreover, *Handai-byoin* adopts a "primary nursing system" where each nurse takes charge of a few patients as a "primary nurse"; in other words, each nurse takes the responsibility of caring her own patients. Therefore, each nurse is expected to autonomously manage her or his schedule, tasks, and mental/physical conditions. On the other hand, Kusakabe-*san*'s autonomy refers to the professionalism of a skilled nurse and her hierarchical position on the nursing team. In the ward, the more skilled, the more influential. Thus although *Chuken* nurses have no difficulty in routine work, they need their seniors' help and advice when they encounter the new or unexpected. Put simply, being a trainee forever is easy because one can avoid responsibility. As her comments indicate, Kusakabe-*san* knew that *Chuken* nurses were actually expected to be independent of their seniors, and, moreover, take on leadership roles in the ward.

However, without clear conceptualization, preceptorship cannot encourage *Chuken* nurses to be autonomous leaders. There is another challenge to autonomy in preceptorship in *Handai-byoin* due to the status of *Chuken* nurses, since preceptorship is still ambiguous even in the United States and the United Kingdom where it has been developed. This ambiguity makes preceptors somewhat at a loss for how to proceed, which immobilizes *Chuken* nurses, who have less power than managerial nurses. For instance, Takata-*san* (4 years of experience, 25 years old) of East-11th told me that she had once felt helplessness because of her ambiguous role.

She had been at a loss to grasp the role of preceptor in 1994, when she was appointed a non-official

preceptor on East-11th. "In April 1994, a prospective burden (of preceptorship) made me melancholic; I thought I had to teach my preceptee from A to Z. But, there was a gap between what people expected to me and what I had imagined; what I actually did was checking her progress, instead of teaching her. Though the actual burden became lighter, it was not what I had thought," Takata-*san* said. Her emotions in first two months were summed up by two words "*Mon-mon*," a mental anguish or distress, and "*Modokashii*," that is, feeling irritated or impatient. She was struggling with her identity as preceptor during these early days, wondering "What am I, after all?". She suffered from the dilemma between the theoretical definition of preceptorship and her own values: "I should have been more committed to my preceptee, but other senior nurses were supporting her. I thought my helping her might be presumptuous to her... I don't like getting the same advice frequently; so I don't like giving the same advice to someone thousands of times. While I was wondering like this, June came, and I had to check her progress based on the check list. Then I finally got a chance to talk to her."

Since preceptors are concerned about the actual practice of preceptorship, they emphasize that the aim of preceptorship is bring up novices as mature, autonomous nurses. The results of domain analysis of *Chuken* nurses' essays show the clear value of autonomy. *Chuken* nurses wrote about four functions of preceptorship:

(A) Encouragement: "Encourage a new nurse by saying, 'You have the talent to be a nurse.' 'Try thinking that our atmosphere allows new nurses to say anything they want to say."

(B) Integration: "Set opportunities to enhance interactions between preceptees and other staff nurses." "A new nurse doesn't belong to his/her preceptor but to all staff nurses in the ward."

(C) Innovation: "Don't continue bad traditions which we hated when we were new nurses." "I thought I should teach in the way that I had wanted in my first year (but it doesn't work)."

(D) Preceptor's pride: "Knowing someone appreciate me motivates us." "I have a pride as a

Chuken nurse." "We should study in advance because preceptees don't respect us until we have abundant knowledge."

They also proposed five rules to successful preceptorship.

(A) Tolerance: "Every nurse was once a novice." "Wait." "When an emergency paralyzed me, a senior nurse, who was always strict to me, let me participate in the treatment, without regarding me as an obstacle."

(B) Balance between strictness and affection: "I want to give my preceptee 'severe attacks with affection.'" "Neither too close to nor too distant from preceptees."

(C) Relaxed attitude: "Take it easy, take it easier," "How about taking a different viewpoint?"

(D) Preceptee's acknowledgement: "Preceptees should ask their preceptors' advice with modest attitude." "Preceptees should feel sorry for their mistakes."

(E) Respect to each other as professional: "We have no difference between senior and junior." "You should interact with us autonomously, because you're already mature working members of the society." "There is no law about preceptorship because the relationship has been jointly created by both of us."

Chuken Nurses in *Handai-byoin* showed professional pride when they spoke of preceptorship. They wanted autonomy, which becomes lost in the forced togetherness of preceptorship. Even though some attempted to turn this disadvantage into an opportunity of self-improvement. While one preceptor wrote in her essay, "It's natural that both of us have some bewilderment because we're a new nurse and a new mentor," another preceptor wrote, "Our relationship is a good stimulus to both of us."

Advice as preceptor's communication pattern

As noted in the last section, Takata-*san* of East-11th was frustrated with her early days in her preceptorship in 1994 because she could not find an opportunity to give advice to her preceptee. Throughout my participant observation, advice was the most frequently observed communication pattern which constitutes preceptorship. Preceptees ran after their preceptor like "goldfish excrement" in need of their preceptor's advice. This advice was primarily the instructions for procedures and organizing tasks. For instance, in the early period of preceptorship, I daily heard preceptors saying to their preceptee, "Let's do that next," "After you've done it, let's go there together," "How about doing that first?" and so on.

Although "a goldfish and its excrement" is a good analogy for the behavioral pattern of preceptorship, it represented only the very early period of preceptorship; after preceptees were in charge of primary care of patients, a more relevant metaphor became "a beehive and a bee." During the first phase, when a preceptee had a problem, she searched for her preceptor to ask for help. When the preceptor's advice did not work, or when it was not clear, the preceptee came back to the preceptor for further instruction. After the task, the preceptee came back to report it to the preceptor. Then, the preceptor usually recommended keeping a record on the private memo-pad or the patient's case record. Finally the preceptee went back to her task. Unlike a beehive, a preceptor had to travel; therefore I sometimes saw preceptees walking around the ward, looking for their preceptor. I also saw preceptors calling preceptee to give her instructions. Since nurses could not waste their time in search of someone, in most cases, they left their messages or asked questions to those who were doing desk work, especially in writing the patients' case records. In these cases, the preceptors' advice was the practitioners'.

On the other hand, preceptors displayed their role as teachers when preceptees were writing their patients' case records. As I have mentioned before, patients' case records reflect nurses' progress. Preceptors sat next to their preceptee and gave comments and answered questions. When preceptees explained their patients' case records to the nurses of the next shift, preceptors would sit next to or behind

them to study their preceptees' writings, listening to their oral reports, and usually gave supplementary information to the nurses on the next shift.

One of the advantages of preceptorship is that preceptors give proper advice to their preceptee in accordance with the preceptee's progress, which the preceptors grasp through their daily interactions. Therefore, preceptors sometimes give instructive comments on their preceptee's tasks to encourage her or him to make quicker progress. When I observed the nursing conference of East-11th, I saw Takata-*san* help Fujimoto-*san* -- her preceptee of the year 1995-96 -- think about observations and inferences in nursing practices. It was on the Friday of Fujimoto-san's second week in East-11th. When Fujimoto-*san* reported her treatment and care for a patient, she said "I don't know the reason why but his phlegm disappeared." A senior nurse asked her, "Think about 'why,' will you?"; then everyone but Fujimoto-*san* burst into laughter. Takata-*san*, who was sitting next to her, stopped laughing and asked her, "Where did that phlegm go?" Immediately she repeated the question differently, "What did YOU do about that phlegm?" Then, she peeped into Fujimoto-*san*'s patient's case record, smiling. During the conference, Takata-*san* said nothing about Fujimoto-*san*'s report except for these two questions; as a preceptor, she understood the difference between the conference for nursing plans and the meetings for information exchanges to the colleagues in the next shift. At the conference, every nurse is much more expected to be autonomous and claim her own opinions. Therefore, Takata-*san* played the role of a good teacher by providing her student with a clue to solving the problem without actual help.

Dilemma of Big Sisters

In the previous section, I discussed how preceptorship was interpreted in terms of the nurses' autonomy: It might threaten or enhance it. On the other hand, some nurses believed that preceptorship

could bring them close friendship. There were positive and negative sides to this connectedness.

Connectedness as Sister-like Friendship

As I mentioned above, Takata-*san* of East-11th had a hard time in defining her role as preceptor in 1994, a trial preceptorship prior to *Handai-byoin*'s official adoption of preceptorship. Takata-*san* finally identified her preceptorship with Iwato-*san* (22 years old) as a sister-like relationship. Iwato-*san* said, "Our feeling is like sisters; we're usually individual; but we're aware of each other: We're preceptor-and-preceptee." Takata-*san* and Iwato-*san* said that they seldom discussed tasks in the ward. "We talk about trivial topics; for example, TV programs, 'That was delicious,' 'That was funny,' and so on. They're just plain topics that we talk about with other 'general' friends (friends who are not nurses)," they said. "Once we enter *Kyukei-shitsu* (nurses' resting room), we never talk about work; it's the place to take a rest. We have to -- want to -- switch our minds (from working mode to private mode)."

Kusakabe-*san*, a new preceptor of East-11th, had envied Takata-*san*'s preceptorship with Iwato-*san* in the previous year. "I envy such a tight bond; they're really getting along well with each other. Various, many things make them to look at each other." On the other hand, she confessed, "I wish I could be a PRECEPTEE again. I want someone to teach me from A." She expected her preceptorship to give her a close relationship at the work place; her other two *Doukis* in East-11th had already left the ward. Two of her *Kouhais* resigned from the hospital in March 1995; thus, she was the second from the bottom in terms of nursing experience except for prospective preceptees. Kusakabe-*san* wanted to have other relational partners than *Sempai*.

Fortunately, Kusakabe-*san*'s dream came true; she could established a sister-like friendship with Iino-*san* (22 years old), her preceptee, though she did not know what a sister was like because she did not

have any female siblings. "I'm glad to have someone to play with. Contrary to preceptor's role, actually, I am the person who is looked after by her. We usually talk about something confidential, saying 'We'd better not tell it anyone in the ward.'"

Her relationship with Iino-*san* transformed Kusakabe-*san*'s inferiority complex into a motivation to self-improvement. She told me, "Each time I see Iino-*chan* ('*Chan*' is a different form of '*San*,' a versatile title for Japanese. Whereas '*San*' is neutral and relatively formal, '*Chan*' is used only to call someone 'lovely' or 'cute,' e.g. siblings, sweetheart, children, friends since childhood, and so on.), who follows me, such an immature nurse, I can't help feeling how lovely she is. So, I want to be a mature nurse because I don't want someone to say 'An incompetent preceptor spoiled her.'" "Iino-*chan* saved me," Kusakabe-*san* said, "Whenever I see Iino-*chan*, I become composed and say to myself, 'OK. She's here. Now I'll do my best!' Actually, (before this preceptorship) I had almost lost myself. It's very difficult to continue this job actively without losing a novice's passion; it's very difficult, though it looks easy."

On the surface, her intimacy to Iino-*san* made Kusakabe-*san* dependent on their relationship. However, this sister-like relationship enabled Kusakabe-*san* to restore her professional passion which she had forgot. Preceptorship made preceptors remind them of their first year. Although other preceptors were not very affectionate to their preceptees as Kusakabe-*san*, they felt close to their preceptees who showed them what they had been, and this closeness made preceptors respect preceptees in some sense. Kiuchi-*san* of West-11th talked about Uchida-*san* (21 years old), her preceptee, "I think I got a nice preceptee. Though I don't know well other preceptees (because they worked with their preceptors) in their early days, Uchida-*san* is the person who was most similar to what I was in my first year among four preceptees. She works very hard, much harder than I did; I did nothing in those days."

Interestingly, one of sister-like relationships even produced similarities in looks and behavioral patters of a preceptor and a preceptee. Yokota-*san* of West-11th established a well-matched relationship

with Sanno-*san* (21 years old), her preceptee; through working together, their behavioral patterns became similar. Since both of them were the tallest nurse and the second tallest in West-11th, when I was observing their night shifts, I could not identify a nurse walking on the dark corridor with a flashlight as either Yokota-*san* or Sanno-*san*. Later, when I talked to Yokota-*san* about that, She laughed and answered, "Yes, everyone says so. We resemble each other"; although their faces were not alike.

Of course, preceptors did not only have fun with their sister-like relationships; they did not forget to encourage them when their preceptee was in a miserable mood. For instance, novice nurses had the trouble in writing patients' case records; and it made them work overtime after other nurses finished their work. When I observed Takata-*san* and Fujimoto-*san*'s Early Night shift on May 24-25, 1995 at East-11th, Takata-*san* said to Fujimoto-*san*, "I'm going to our resting lounge," then withdrew from the nurses' station at 2:21 AM. Actually, she was taking a nap at the lounge, waiting for Fujimoto-*san*. It was at 3:52 AM that Takata-san left the resting lounge with Fujimoto-*san*. Both of them lived in the hospital's dormitory for single nurses, which was located near to the hospital, only three minutes on foot; therefore, Takata-*san* had no reason for waiting for her preceptee in terms of transportation (Nurses in the Early Night shift go home by taxicabs paid by the hospital unless they live in the dormitory or own cars). "Going home together" was a kind of ritual for most of my informants, which prevented preceptees from being left alone -- alone in helplessness.

Big Sisters' Tolerance

On the contrary, preceptors were perplexed by the difference between what they had been and what their preceptees actually were. They knew that what they had thought in their memories were affected by their experiences as *Chuken* nurses because they were no longer novices. When I presented preceptors' voices at *Chuken* nurses' workshop in June 1995, preceptors were surprised and upset at preceptees' "frank and honest" (from some preceptors' words) responses. Motokawa-*san* of West-11th was shocked at preceptors' words, and wrote an essay titled "Preceptors are also human beings!" Below is an excerpt

from her essay.

> For "*Oba-san*," ("*Oba-san*" means middle-aged woman, though 26 years old is not regarded as middle-aged in contemporary Japanese society.) many things about this new generation are not understandable. Though we, this generation of preceptors, were once called *Shin-jinrui* (*Neo Homo sapiens*) a long time ago, they, the generation of preceptees, are Hyper *Shin-jinrui*, who have nothing to fear; they look at us from terribly severe viewpoints. When we continuously work together in the same shifts, we are getting to have more and more stress little by little; so we are even. But, they keep away from us, saying "I feel awkward;" "She behaves as if she was middle aged;" "She is just a nag." On the other hand, in the wards where we do not have enough contacts to them to get closer, they depreciate us as "the women who suddenly appear in front of us when we have to fill in the checklists, and who call themselves 'preceptors,'" though we're just keeping our eyes on them keeping some distance. We try to be sensitive to their needs, and offer them our warm-hearted hands with angels' smile, saying, "Ask me whatever you don't understand." But if their responses are like "We're in trouble because we can't figure out what we don't understand about nursing. After all, we'd better commiserate with our *Douki*," we would feel a little sad.

After lamenting that preceptors were not sufficiently acknowledged, Motokawa-*san*'s essay concluded, referring to her expectation that preceptees' progress would tell them what their preceptors thought.

> I wonder if my wish reaches their hearts.
>
> I wonder if they will understand us when they are regarded as *chuken* and appointed to preceptors.
>
> Though...it would be if they continue their jobs till then....

Takata-*san* of East-11th, who also participated in the workshop, agreed with this opinion. She told me, "I was offended. But it's reasonable: Novices do not know how other people are supporting them." Also, Yokota-*san* of West-11th, a friend of Takata-*san*'s, said to me, "Everyone who went to the workshop was angry at preceptees' responses you presented. But when we were novices, we didn't

consider the thought of those who taught us. There are something you don't understand until you teach somebody. But those who don't appreciate teachers tend to quit the hospital, don't they?"

Through analyzing how preceptors responded to preceptees' responses to their preceptorship, I found how preceptors' pride was constructed. Although offended, they recognized that preceptees' responses were the evidence of their immaturity due to their lack of experiences and also the evidence of preceptors' maturity. Preceptorship also reminded preceptors of their immature days; comparing what they were from what they had been showed them their progress, which confirmed their professional pride.

Discussion

The nurses in *Handai-byoin* did not feel so much difficulty in anchoring a foreign concept to their nursing practices and education. They interpreted preceptorship by their own ways, comparing it with similar concepts. However, its togetherness, one of primary concepts of preceptorship provoked controversial utterances.

Morrow's (1984) four functions model did not appear in preceptors' discourse about their preceptorship. Instead, they talked about themselves -- the values of nurses, and their beliefs of ideal nurses. What they conceptualized was not preceptorship but their own status as *Chuken* (mid-range) nurses: not yet mature but no longer immature, and also their pride of being a nurse: an independent expert who can make judgement autonomously.

Preceptorship was localized in *Handai-byoin* by the metaphor of "sister." However, this is quite different from the "family flavor" which Kondo (1990) points out as a Japanese way of constructing self in Japanese organizations. In *Handai-byoin*, nurses did not compare their wards to "families." They chose the metaphor of "sister" to account for preceptorships because preceptors and preceptees have no right to choose their partner; just like sisters, mandatory relationships are assigned to them. Nurses cannot escape from the relationships. Even if they hate each other, they are called "a preceptor and a preceptee" until their preceptorship is officially over. Throughout my fieldwork, I did not hear any "collectivistic" value for the

hospital's interest except for a Head Nurse's words: "Whatever preceptorship will do unless a novice quits the job." What I saw in their organizational culture was not hierarchically structured relationships based on obligations (Kondo, 1990) but dynamic interplays between autonomy and connectedness (Baxter & Montgomery, 1996).

The next question is what preceptorship meant to preceptors' organizational positions in their nursing teams. Both Head Nurses' views of preceptorship might help me answer. Shimura-*fucho-san* of West-11th told me that she appointed the four nurses of West-11th to preceptors because she wanted to give them a chance. She said, "Fourth or fifth year nurses wish they would be appreciated. My role is turning such a wish into their motivation to practice." She thought preceptorship provides both preceptees and preceptors with the opportunity to widen their perspectives on nursing. "There's no template of nursing," she said.

Indeed, Takata-*san* of East-11th, who experienced two preceptorships, with Iwato-*san* in 1994, and with Fujimoto-*san* (21 years old) in 1995, wrote that, "There is no law about preceptorship" in her essay. She told me, "It is very beneficial to me to experience two preceptorships." She struggled with conceptualization of preceptorship in her first preceptorship; from this struggle, she learned that preceptorship should be flexible in accordance with preceptee's or organization's need. This flexibility enabled her to set her own objective in her tasks easily. "Now I know I don't have to carry all burden on my back, but once I didn't notice I got carried away by the pressure I created by myself," she said. "I wasn't aware of other people's support."

Fujiwara-*fucho-san* of East-11th emphasized that each nurse must have her own perspective. Indeed, preceptorship would be successful if new graduates did not resign. And it would be a good exercise of leadership. However, she pointed out something much more important in preceptorship; "Preceptor looks at one person through various filters (made from various people's values), and finally, discovers a part of herself that she had never recognized." Kusakabe-*san* of East-11th responded to her expectation. Through preceptorship with Iino-*san*, she discovered her new view of patients. She told me, "It's not a relationship between a nurse and a patient; rather, it is a relationship between two equal

persons, who contact to each other and progress together -- I want to be a nurse who can establish such a relationship."

My research does not answer the question whether preceptorship is good or bad. Instead, I would answer that it would be an experiment which provides nurses with an opportunity to rethink of their view of nursing and human relationships. I conclude this paper by referring to Kusakabe-*san*'s words, "Now I've found relating is interesting."

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